



Report into the Floating Bridge Incident of
26 September 2018


Health and Safety Advisor

Health, Safety and Welfare Team

Guide to abbreviations

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Executive Summary

On 26 September 2018 [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]. As it could not be moved the Floating Bridge ran aground and remained in position until the hydraulic oil system was repaired and could be re-floated on the first high tide on the 27 September 2018

- [REDACTED]
[REDACTED]
[REDACTED]
- There appears to be discrepancies between the accounts of floating bridge staff and managers at County Hall regarding the decision to keep the service operating once the leak had started.
- There is over-reliance on the expertise of floating bridge staff by managers when making operational decisions.
- [REDACTED]
[REDACTED]
[REDACTED].
- No method statements exist for safety critical activities.
- Risk assessments associated with engineering activities on the bridge are neither suitable nor sufficient.
- Inadequate consideration has been given to staff well-being given how public facing they are as well as the large-scale negative press reporting in relation to the Floating Bridge.

Action Plan

- [REDACTED]
[REDACTED]
[REDACTED]
- Review and update all risk assessments and method statements associated with engineering activities on the floating bridge and ensure they are suitable and sufficient.
- Ensure staff receive regular 121 sessions as per council policy.
- Carryout a wellbeing survey for staff.
- Better arrangements for lone working below decks need to be provided.

Introduction

On 26 September 2018 work to change the hydraulic oil filter in the floating bridge led to a leak of hydraulic fluid into the engine room. The [REDACTED] was not able to remedy this problem and called an engineer to fix the problem who advised they would be about 3 hours. The decision was taken to keep the floating bridge in service which had the effect of exacerbating the leak. [REDACTED]

A preliminary investigation was carried out by [REDACTED] from [REDACTED] Marico in his capacity as the floating bridge's Designated Person Ashore, which recommended that a full internal investigation be carried out. The Council's Health, Safety and Welfare Team were asked to conduct this investigation. For full terms of reference please see appendix 1.

A note about limitations

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] Irrespective of which exact details are correct however the recommendations from this report would still stand.

Narrative

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

The process itself is straight forward and the [REDACTED] report summarised it as follows:

1. Shut down the hydraulic system i.e. take FB6 out of service

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2. Remove the four flange bolts from the filter housing on top of the hydraulic tank which also has the return oil pressure gauge as part of the fitting
3. Lift off the housing and remove old filter
4. Clean surrounding area and fit new filter
5. Replace housing cover and oil return pressure gauge and four bolts
6. Tighten down accordingly
7. Start-up hydraulic system and test for leaks
8. FB returns to service

[REDACTED]

- [REDACTED]
- [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Regardless of what the precise sequence of events was, for our purposes the outcome is that there was a leak from the hydraulic oil tank which couldn't be stopped due to one of the bolts being cross-threaded so it couldn't be tightened enough to reseal the housing.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

The outcome of this conversation, whichever version is correct, is that FB6 was to remain in service until the engineer arrived.

[REDACTED]

Unfortunately the position of the CCTV camera is such that the specifics of what happened on the top of the hydraulic tank cannot be verified. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

The vessel then remained of the east side of the Medina, eventually becoming grounded, whilst the emergency services (Police, Fire, Ambulance, Coast Guard and an Air Ambulance) attended the scene.

[REDACTED]

[REDACTED]

[REDACTED]

Following repairs FB6 was re-floated the following day and resumed operation.

Analysis

I have split this into a number of themes to enable full exploration of the issues. These are the [REDACTED] the task being attempted, the health and safety management system in relation to engineering on FB6 and the management of the service.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Recommendation: regular 121 sessions should be instituted for floating bridge staff as per Council policy.

[REDACTED]

[REDACTED] Given the many changes and negative publicity in relation to the floating bridge the Council as the employer should be supporting staff and a good start would be to conduct a wellbeing survey amongst staff to identify the key stressors to be addressed.

Recommendation: carryout a wellbeing survey amongst floating bridge staff.

The Filter Change Task

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Risk Assessment and Method Statements (RAMS)

As part of the investigation copies of the risk assessments and method statements were requested for the task being carried out and in relation to the below decks engineering generally. Whilst there are a number of good risk assessments relating to the operation of the floating bridge generally that can be found in the vessel's domestic safety manual, the ones relating to the engineering spaces were only to found on the engineer's tablet and were not easily accessible without him.

This lack of easy access to the risk assessments for working in this space is of concern as should the existing engineer not be present, for example if he was on leave, then staff or contractors working in those areas would not access to them, potentially putting them at risk.

A review of the risk assessments and method statements, once they were obtained, showed that they were neither suitable nor sufficient. This is because they are very generalised and lack the necessary detail to be effective.

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For example, the risk assessment identifies a hazard of “engaged in engine room activities” without specifying what these activities might be or making any acknowledgement that different activities are very likely to have different hazards associated with them.

The control measures “master informed of entrance to the engine room”, “correct PPE to be worn” and “isolate engine before commencing work if required” are not adequate for the full range of tasks carried out in the engine room and in the case of PPE and isolate engine leave areas of doubt likely to lead to hazards being uncontrolled (as indeed happened in the incident under discussion.)

The result of this is that the RAMS appear to be not fit for purpose as they fail to identify the significant hazards associated with engineering work on the bridge in sufficient detail and therefore fails to ensure that the risks are sufficiently controlled.

Recommendation: Ensure that suitable and sufficient risk assessments are carried out. These must take the form of both general environmental risk assessments and specific detailed task-based risk assessments. Once completed the risk assessments must be readily accessible to all who may need them. More complex or hazardous tasks also need to have specific method statements in place.

Lone Working

Although [REDACTED] was not lone working at the time of the incident, as can clearly be seen upon viewing the activity of the emergency services in the engine room on CCTV, there are a number of places someone could fall and not be seen by the cameras. This raises the concern that if a member of staff were to fall over and require help it could easily not be visible from the CCTV system and result in them not receiving help in sufficient time.

Recommendation: Introduce a formal system for controlling lone working below decks. This system will need to consist of a method of identifying when help would be needed, a means of raising the need for help to others and an expected response from the crew or other identified persons in a timely way. This could for example consist of an electronic system incorporating a “man down” device or similar.

Conclusion

The incident on the floating bridge on 26 September was a compound incident [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED].

It is very fortunate that another member of staff had voluntarily decided to stay and assist in the operation being attempted and was on hand to quickly summon aide. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

All of the above is against a backdrop of an inadequate RAMS that failed to identify or control significant hazards associated with the task being attempted.

Action Plan

- [REDACTED]
[REDACTED]
[REDACTED]
- Review and update all risk assessments and method statements associated with engineering activities on the floating bridge and ensure they are suitable and sufficient.
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- Better arrangements for lone working below decks need to be provided

Appendix 1

Terms of reference

Floating Bridge Investigation

- To investigate the events leading to the incident on the floating bridge on 26 September 2018
- To identify whether the health and safety procedures and practices in place on the floating bridge were adequate
- To consider and report on any learning points identified as a result of these events including:
 - Whether any change in policy or practice would help to prevent a re-occurrence of the events leading to the school closure
 - Whether the incident highlights any good practice that should be shared
- To report findings to senior managers within the Isle of Wight Council who will determine if any further action is required
- This investigation is not a formal investigation under the Council's disciplinary procedures